FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040857

Facility Name: Parkway Healthcare Center

Address: 219 East Parkway Drive (Number) Wheaton (City) 60187 (Zip Code)

County: Lee

Telephone Number: (630) 688-4635 **Fax #** (630) 668-4649

IDPA ID Number: 35-1947211002

Date of Initial License for Current Owners: 06/07/1994

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		x	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Sherry DeBons **Telephone Number:** (281) 579-5022

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Linda Holtzscheiter

(Title) Reimbursement Manager

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) N/A

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Parkway Healthcare Center # 0040857 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	35	Skilled (SNF)	35	12,775	1
2		Skilled Pediatric (SNF/PED)			2
3	34	Intermediate (ICF)	34	12,410	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	69	TOTALS	69	25,185	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,450	2,271	1,119	6,840	8
9	SNF/PED					9
10	ICF	5,827	2,060	79	7,966	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,277	4,331	1,198	14,806	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.79%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 06/07/1994

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 06/07/1994 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 35 and days of care provided 957

Medicare Intermediary AdminStar Illinois

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Parkway Healthcare Center # 0040857 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	168,230	6,659	4,325	179,214		179,214		179,214			1
2	Food Purchase		82,765		82,765		82,765	(489)	82,276			2
3	Housekeeping	83,737	6,626		90,363		90,363		90,363			3
4	Laundry	54,457	8,731		63,188		63,188		63,188			4
5	Heat and Other Utilities			65,423	65,423		65,423	16	65,439			5
6	Maintenance	31,259	28,634	17,924	77,817		77,817	50	77,867			6
7	Other (specify):* Waste/ garbage -See Pg 3.1			11,098	11,098		11,098		11,098			7
8	TOTAL General Services	337,683	133,415	98,770	569,868		569,868	(423)	569,445			8
	B. Health Care and Programs											
9	Medical Director			15,400	15,400		15,400		15,400			9
10	Nursing and Medical Records	888,217	40,090	237,294	1,165,601		1,165,601	5,241	1,170,842			10
10a	Therapy	8,596	1,894	24,840	35,330		35,330		35,330			10a
11	Activities	52,377	2,997	2,828	58,202		58,202		58,202			11
12	Social Services	20,802	41	2	20,845		20,845		20,845			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	969,992	45,022	280,364	1,295,378		1,295,378	5,241	1,300,619			16
	C. General Administration											
17	Administrative	77,411			77,411		77,411		77,411			17
18	Directors Fees			115	115		115		115			18
19	Professional Services							4,180	4,180			19
20	Dues, Fees, Subscriptions & Promotions			35,450	35,450		35,450	(2,069)	33,381			20
21	Clerical & General Office Expenses	98,419	6,987	304,632	410,038		410,038	(162,951)	247,087			21
22	Employee Benefits & Payroll Taxes			228,193	228,193		228,193		228,193			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,811	6,811		6,811	7,460	14,271			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			46,189	46,189		46,189	(5,940)	40,249			26
27	Other (specify):*											27
28	TOTAL General Administration	175,830	6,987	621,390	804,207		804,207	(159,320)	644,887			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,483,505	185,424	1,000,524	2,669,453		2,669,453	(154,502)	2,514,951			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Parkway Healthcare Center #0040857 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			306,310	306,310		306,310	(151,110)	155,200			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			50,451	50,451		50,451	195	50,646			33
34	Rent-Facility & Grounds							1,317	1,317			34
35	Rent-Equipment & Vehicles							2,973	2,973			35
36	Other (specify):* See Pg 4.1			8,770,530	8,770,530		8,770,530	(8,763,667)	6,863			36
37	**TOTAL Ownership**			9,127,291	9,127,291		9,127,291	(8,910,292)	216,999			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		50,433	125	50,558		50,558		50,558			39
40	Barber and Beauty Shops			50	50		50	(50)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			37,777	37,777		37,777		37,777			42
43	Other (specify):* See Pg 4.1			23,511	23,511		23,511		23,511			43
44	**TOTAL Special Cost Centers**		50,433	61,463	111,896		111,896	(50)	111,846			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,483,505	235,857	10,189,278	11,908,640		11,908,640	(9,064,844)	2,843,796			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Parkway Healthcare Center # 0040857 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(489)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income		32		10
11	Discounts, Allowances, Rebates & Refunds		21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(37,766)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(66,771)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(613)	20		28
29	Other-Attach Schedule	(9,086,940)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (9,192,579)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	127,735		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 127,735		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (9,064,844)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Parkway Healthcare Center

ID# 0040857

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sales Taxes	$ (502)	21	1
2	Small Balance Adjustments	0	21	2
3	Memorium/ Benevolance	0	21	3
4	Depreciation Reconciliation	(90,816)	30	4
5	Activities Program Receipts	0	11	5
6	Depreciation Reconciliation	(60,294)	30	6
7	Professional Liability Insurance	(6,290)	26	7
8	Barber & Beauty	(50)	40	8
9	Public Relation Expense	0	20	9
10	Non Allowable Advertising	(2,014)	20	10
11	Entertainment	(60)	24	11
12	Fresh Start	(8,770,530)	36	12
13	Laundry Receipts	(4,400)	21	13
14	Vending Reciepts	(168)	21	14
15	Misc Reciepts	0	21	15
16	Marketing Wages	0	21	16
17	Maketing Bonus	0	21	17
18	Marketing Holiday	0	21	18
19	Marketing Sick	0	21	19
20	Marketing Vacation	0	21	20
21	Marketing Overtime	0	21	21
22	Legal Fees -Bankrupcty	0	21	22
23	Contributions -Donations	(154)	21	23
24	Mgt Fees Expense	(81,374)	21	24
25	Other direct Expense - Marketing	(5,848)	21	25
26	Gain/Loss on Sale of Assest -Adminstrative	(8,866,025)	21	26
27	Gain/Loss on Sale of Assest -Bankruptcy	8,801,585	21	27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(9,086,940)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Parkway Healthcare Center # 0040857 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(489)	0	0	0	0	0	0	0	0	0	0	(489)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	16	0	0	0	0	0	0	0	0	0	16	5
6	Maintenance	0	50	0	0	0	0	0	0	0	0	0	50	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(489)	66	0	0	0	0	0	0	0	0	0	(423)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	5,241	0	0	0	0	0	0	0	0	0	5,241	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	5,241	0	0	0	0	0	0	0	0	0	5,241	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,180	0	0	0	0	0	0	0	0	0	4,180	19
20	Fees, Subscriptions & Promotions	(2,627)	558	0	0	0	0	0	0	0	0	0	(2,069)	20
21	Clerical & General Office Expenses	(261,423)	98,472	0	0	0	0	0	0	0	0	0	(162,951)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(60)	7,520	0	0	0	0	0	0	0	0	0	7,460	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(6,290)	350	0	0	0	0	0	0	0	0	0	(5,940)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(270,400)	111,080	0	0	0	0	0	0	0	0	0	(159,320)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(270,889)	116,387	0	0	0	0	0	0	0	0	0	(154,502)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Parkway Healthcare Center # 0040857 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(151,110)	0	0	0	0	0	0	0	0	0	0	(151,110)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	195	0	0	0	0	0	0	0	0	0	195	33
34	Rent-Facility & Grounds	0	1,317	0	0	0	0	0	0	0	0	0	1,317	34
35	Rent-Equipment & Vehicles	0	2,973	0	0	0	0	0	0	0	0	0	2,973	35
36	Other (specify):*	(8,770,530)	6,863	0	0	0	0	0	0	0	0	0	(8,763,667)	36
37	**TOTAL Ownership**	(8,921,640)	11,348	0	0	0	0	0	0	0	0	0	(8,910,292)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(50)	0	0	0	0	0	0	0	0	0	0	(50)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(50)	0	0	0	0	0	0	0	0	0	0	(50)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(9,192,579)	127,735	0	0	0	0	0	0	0	0	0	(9,064,844)	45

Facility Name & ID Number Parkway Healthcare Center # 0040857 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mariner Health Care	100	See Attached page 6.1		Mariner Health Care	Atlanta, GA	Management

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Mariner Health Care	100.00%	$ 16	$ 16	1
2	V	6	Repair & Maintenance		Mariner Health Care	100.00%	50	50	2
3	V	19	Professional Services		Mariner Health Care	100.00%	4,180	4,180	3
4	V	20	Fees, Subscription, Promotions		Mariner Health Care	100.00%	558	558	4
5	V	10	Nursing & Medical Records		Mariner Health Care	100.00%	5,241	5,241	5
6	V	21	Clerial & General Office Exp		Mariner Health Care	100.00%	98,472	98,472	6
7	V	24	Travel & Seminar		Mariner Health Care	100.00%	7,520	7,520	7
8	V	26	Insurance Premium		Mariner Health Care	100.00%	218	218	8
9	V	36	Depreciation		Mariner Health Care	100.00%	6,863	6,863	9
10	V	33	Taxes - Property		Mariner Health Care	100.00%	195	195	10
11	V	35	Rental & Leasing		Mariner Health Care	100.00%	2,973	2,973	11
12	V	34	Lease Expense		Mariner Health Care	100.00%	1,317	1,317	12
13	V	26	Property Insurance		Mariner Health Care	100.00%	132	132	13
14	Total			$			$ 127,735	$ * 127,735	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Parkway Healthcare Center # 0040857 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Parkway Healthcare Center # 0040857 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Mariner Health Care
Street Address: One Ravine Dr. Suite 1500
City / State / Zip Code: Atlanta, GA 30346
Phone Number: ((770) 379-8203
Fax Number: ((770) 399-1971

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities				$ 192	$		$ 16	1
2	6	Repair & Maintenance				556			50	2
3	19	Professional Services				50,336			4,180	3
4	20	Fees, Subscription, Promotions				6,593			558	4
5	10	Nursing & Medical Records				675,703			5,241	5
6	21	Clerial & General Office Exp				527,522			98,472	6
7	24	Travel & Seminar				84,515			7,520	7
8	26	Insurance Premium				2,427			218	8
9	36	Depreciation				81,021			6,863	9
10	33	Taxes - Property				2,346			195	10
11	35	Rental & Leasing				35,937			2,973	11
12	34	Lease Expense				15,801			1,317	12
13	26	Property Insurance				1,581			132	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,484,530	$		$ 127,735	25

Facility Name & ID Number Parkway Healthcare Center # 0040857 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Parkway Healthcare Center # 0040857 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	10,507	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	45,843	2
3. Under or (over) accrual (line 2 minus line 1).	$	35,336	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	15,115	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	50,451	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	43,179	8
	1998	4,468	9
	1999	44,481	10
	2000	51,258	11
	2001	45,843	12

Line 1 adjusted or not equal to prior C/R due to intercompany entries.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Parkway Healthcare Center COUNTY Lee

FACILITY IDPH LICENSE NUMBER 0040857

CONTACT PERSON REGARDING THIS REPORT Sherry DeBons

TELEPHONE 281-579-5022 FAX #: 281-578-4779

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-09-108-051	Parkway HealthCare	$ 44,582.42	$ 44,582.42
2.	05-09-108-052	Parkway HealthCare	$ 530.44	$ 530.44
3.	05-09-108-053	Parkway HealthCare	$ 734.66	$ 734.66
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 45,847.52	$ 45,847.52

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Parkway Healthcare Center # 0040857 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,015 B. General Construction Type: Exterior Brick Frame Metal Studs/Block Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	177,824	1994	$ 89,739	1
2					2
3	TOTALS	177,824		$ 89,739	3

Facility Name & ID Number Parkway Healthcare Center # 0040857 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	69		1994	1967	$ 2,830,321	$ 80,866	35	$ 80,866	$	$ 692,980	4
5			1994		21,660	1,083	20	1,083		9,009	5
6											6
7											7
8											8
	Improvement Type**										
9	Door /Handlrails			1995	4,455	223	20	223		1,607	9
10	Cooler Repair			1996	780	78	20	39	(39)	314	10
11	Kitchen Drain			1996	1,350	135	20	68	(67)	560	11
12	Roofing			1996	36,125	1,806	20	1,806		11,801	12
13	Painting			1996	6,400	320	20	320		2,042	13
14	Awnings			1996	2,610	131	20	131		830	14
15	Gutters			1996	2,024	101	20	101		656	15
16	Roof Replacement			1996	36,125	1,806	20	1,806		11,588	16
17	Water Heater			1996	2,481	248	20	124	(124)	1,085	17
18	Plumbing Valves			1996	2,367	237	20	118	(119)	802	18
19	Install Faucets			1997	4,728	236	20	236		1,261	19
20	HI-Lo Mixing Value			1997	3,118	312	20	156	(156)	976	20
21	Bathroom repairs			1997	2,806	140	20	140		786	21
22	Ceiling Repair			1997	714	36	20	36		207	22
23	Door Knob Convertors			1997	1,374	69	20	69		401	23
24	Walk-In Freezer			1997	920	92	20	46	(46)	281	24
25	Sprinkler System			1997	6,370	637	20	319	(318)	1,811	25
26	Reapir Water Heater			1997	718	72	20	36	(36)	204	26
27	Repair A/C			1997	777	78	20	39	(39)	221	27
28	Water Heater			1997	979	98	20	49	(49)	258	28
29	Architect Drawing			1997	1,684	84	20	84		472	29
30	Acquisition Building Improvement			1994	413,916	15,651	20	15,651		152,127	30
31	Acquisition -Land Improvement			1994	21,892	1,094	20	1,094		9,377	31
32	Architect Drawing			1998	3,043	76	20	76		380	32
33	Water Heater Boosters			1998	979	24	20	24		120	33
34	Walk-IN cooler			1994	543	54	20	27	(27)	325	34
35	Adjustment to Reconcile to Book Depre 1998			1998		129,201			(129,201)		35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Parkway Healthcare Center # 0040857 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Transfer Switch Generator	2000	$ 3,743	$ 187	20	$ 187	$	$ 468	37
38	Ejector Pump - First Half	2000	8,247	412	20	412		1,065	38
39	Ejector Pump - Second Half	2000	8,247	412	20	412		1,065	39
40	Rplc Entry Admin Office	2000	4,400	880	5	880		1,907	40
41	Remove & Install control Panel	2000	1,500	75	20	75		163	41
42	Parking Lot Seal & Restrip	2000	3,600	180	20	180		420	42
43	Dupont Carpat Entry Adminstration	2001	4,400	880	5	880		1,760	43
44									44
45	3; Tabs Basic Wchr	2002	386	42	10	42		42	45
46	5:Tabs, Basic Dual lock	2002	497	54	10	54		54	46
47	Instl Mixing Value	2002	2,912	267	10	267		267	47
48	69: Instl Overbed Lights 50% Dep	2002	2,500	229	10	229		229	48
49	69: Instl Overbed Lights 50% Dep	2002	2,500	188	10	188		188	49
50	150 : Fluorescent Lights & Use Tax	2002	399	30	10	30		30	50
51	69: Overbed light Fixtures & Use Tax	2002	5,848	487	10	487		487	51
52	Control Panel -Fire Alarm	2002	2,743	183	10	183		183	52
53	Foundation & Draining Repairs	2002	7,500	188	20	188		188	53
54	Base Board Heating Instl	2002	9,900	330	10	330		330	54
55	Remove Drywall, Firestriping (Bal Due)	2002	960	27	15	27		27	55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,481,542	$ 240,038		$ 109,817	$ (130,221)	$ 911,353	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Parkway Healthcare Center # 0040857 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 310,297	$ 31,852	$ 31,852	$	var	$ 196,967	71
72	Current Year Purchases	38,336	13,532	13,532		var	13,532	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 348,633	$ 45,384	$ 45,384	$		$ 210,499	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,919,914	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 285,421	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 155,200	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (130,221)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,121,852	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	O/H Allocation 1996	$ 6,278	$ 314	$ (1,289)	86
87	O/H Allocation 1997	1,639	82	435	87
88					88
89					89
90					90
91	TOTALS	$ 7,917	$ 396	$ (854)	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Parkway Healthcare Center # 0040857 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 8,815 Description: Copier & helium Tank -See Attachment 0 Pg 14.1
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Parkway Healthcare Center # 0040857 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

[ ] YES
[x] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER AIDE ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	60 hrs	$ 1,521	309	$ 2,628	$ 0	369	$ 4,149	1
2	Licensed Speech and Language Development Therapist	10a	hrs		608	6,698	0	608	6,698	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	29 hrs	915	2,541	13,343	260	2,570	14,518	4
5	Physician Care		visits							5
6	Dental Care	39	visits			125			125	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				45,346		45,346	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$ 2,436	3,458	$ 22,794	$ 45,606	3,547	$ 70,836	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Parkway Healthcare Center # 0040857 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,300	$	1
2	Cash-Patient Deposits	70,117		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,644		3
4	Supply Inventory (priced at)	15,964		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	215,793		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 308,818	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	3,331,659		13
14	Buildings, at Historical Cost	4,279,846		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	222,070		16
17	Accumulated Depreciation (book methods)	(1,552,274)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	62,583		19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See attachment Schd 17.1	277		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 6,344,161	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,652,979	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 45,443	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	86,194		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	15,115		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schd 17.1			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 146,752	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See attached Schd 17.1			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 146,752	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 6,506,227	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,652,979	$	48

*(See instructions.)

Facility Name & ID Number Parkway Healthcare Center # 0040857 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,255,455	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,255,455	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(9,671,182)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (9,671,182)	17	
	B. Transfers (Itemize):			
18	**Fresh Start Acctg Due to Bankrupty**	13,921,954	18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$ 13,921,954	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 6,506,227	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Parkway Healthcare Center # 0040857 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,198,861	1
2	Discounts and Allowances for all Levels	(242,852)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,956,009	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	80,781	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 80,781	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	299	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	92,400	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,024	19
20	Radiology and X-Ray	13,015	20
21	Other Medical Services	79,702	21
22	Laundry	4,400	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 198,840	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Receipts	168	28
28a	Miscellanceous Receipts	1,660	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,828	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,237,458	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	569,868	31
32	Health Care	1,295,378	32
33	General Administration	804,207	33
	B. Capital Expense		
34	Ownership	9,127,291	34
	C. Ancillary Expense		
35	Special Cost Centers	74,119	35
36	Provider Participation Fee	37,777	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,908,640	40
41	**Income before Income Taxes (line 30 minus line 40)****	(9,671,182)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (9,671,182)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Parkway Healthcare Center # 0040857 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,715	1,842	$ 55,658	$ 30.22	1
2	Assistant Director of Nursing	1,911	2,052	52,788	25.73	2
3	Registered Nurses	8,106	8,704	236,613	27.18	3
4	Licensed Practical Nurses	4,690	5,037	114,097	22.65	4
5	Nurse Aides & Orderlies	28,293	30,382	395,716	13.02	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	89	128	3,089	24.13	7
8	Rehab/Therapy Aides	243	350	5,506	15.73	8
9	Activity Director	2,117	2,284	31,025	13.58	9
10	Activity Assistants	2,121	2,288	21,351	9.33	10
11	Social Service Workers	1,216	1,278	20,802	16.28	11
12	Dietician					12
13	Food Service Supervisor	1,768	1,891	30,756	16.26	13
14	Head Cook	5,045	5,397	60,544	11.22	14
15	Cook Helpers/Assistants	9,404	10,060	76,930	7.65	15
16	Dishwashers					16
17	Maintenance Workers	1,829	1,873	31,259	16.69	17
18	Housekeepers	7,874	8,263	83,737	10.13	18
19	Laundry	4,540	4,959	54,457	10.98	19
20	Administrator	2,053	2,187	81,506	37.27	20
21	Assistant Administrator					21
22	Other Administrative	2,046	2,179	40,328	18.51	22
23	Office Manager					23
24	Clerical	4,235	4,510	53,995	11.97	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,863	2,014	33,345	16.56	31
32	Other Health Ca MCare Coord/ Case Mgt					32
33	Other(specify) Mkting & Transporation					33
34	TOTAL (lines 1 - 33)	91,158	97,678	$ 1,483,502 *	$ 15.19	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	99	$ 3,958	1 - 3	35
36	Medical Director	96	15,400	9 - 3	36
37	Medical Records Consultant	8	344	10-3	37
38	Nurse Consultant	137	6,241	10- 7	38
39	Pharmacist Consultant	22	961	10 - 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	50	2,774	11 - 3	44
45	Social Service Consultant			12 - 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	412	$ 29,677		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,861	$ 88,462	10 - 3	50
51	Licensed Practical Nurses	132	5,643	10 - 3	51
52	Nurse Aides	2,380	61,763	10 - 3	52
53	TOTAL (lines 50 - 52)	4,373	$ 155,869		53

Facility Name & ID Number Parkway Healthcare Center # 0040857 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sandra L. Gourley	Adminsrtator	100	$ 37,372
Pamela Lee	Adminsrtator	100	24,232
Connie Trunk	Adminsrtator	100	15,807
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 77,411

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
		$
Legal (SEE ATTACHED)	Legal Fees	115
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 115

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 36,800
Unemployment Compensation Insurance	19,211
FICA Taxes	109,783
Employee Health Insurance	49,999
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension/Retirement	5,719
Insurance Life	1,706
Other Benefits	4,975
Home Office Allocation	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 228,193

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	26,272
Health Care Worker Background Check	
(Indicate # of checks performed)	1,862
Other Licenses Fees	1,659
Dues	2,818
Home Office Allocation	558
Total Advertising	3,016
Less: Public Relations Expense	(177)
Non-allowable advertising	(2,014)
Yellow page advertising	(613)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 33,381

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	5,206
Home Office Allocation	7,520
Seminar Expense	1,605
Entertainment Expense	(60)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,271

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Parkway Healthcare Center # 0040857 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Parkway Healthcare Center # 0040857 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois HealthCare Association - $ 2,818**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? _____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **0**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

STATE OF ILLINOIS

Facility Name & ID Number Parkway Healthcare Center # 0040857 **Ending:** 12/31/2002

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Operating Expense - Line 7	Amount
Infectious Waste Disposal <> Default <> Nursing Admin/Supv	1,915
Infectious Waste Disposal <> Default <> Physical Plant	30
Garbage Service <> Default <> Physical Plant	9,183
	11,128

Health Care Program - Line 15	Amount
N/A	
	0

General & Adminstrative - Line 27	Amount
N/A	
	0

Inservice Education - Line 23 Column 3 (over $2,000)	Amount
N/A	
	0

STATE OF ILLINOIS

Facility Name & ID Number Parkway Healthcare Center # 0040857 Ending: 12/31/2002

Meals - adjustment

14,806	Days (Total Patient days)
3	Mult (3 meals a day)
44418	Sub total
264	meals to employess (reported by facility)
44682	Add Sub
82,765	Divide -Pg 3, line 2, column 2
1.85	Cost per meal

1.85	Cost per meal
264	mult - meal to employees
489	= adjust for pg 2, line 2, column2

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Ownership - Line 36	Amount
Fresh Start Acctg Adj <> Bankrupty Exp Acq <> Cost Non Overhead	8,770,530
Home Office - Depreciation	6,863
	8,777,393

Ancillary Expenses - Line 43 -Column 2	Amount
Ancillary Supplies <> Default <> Laboratory	0
	0

Ancillary Expenses - Line 43 -Column 3	Amount
Contract Svcs - Chgbl <> Default <> Laboratory	681
Contract Svcs - Chgbl <> Default <> X/Ray	9,706
Professional Services Chgble <> Default <> X/Ray	0
Professional Services Chgble <> General / Other <> X/Ray	0
	10,387

Related Illinois Nursing Homes as of 12/31/2002

Group Name	Related Illinois Nursing Homes	Illinois Facility Number
Mariner Health Care	Dixon HealthCare Center	0040865
	LaSalle Health & Rehabilitation Center	0037671
	Litchfield HeathCare Center	0037689
	Montebello HeathCare Center	0031468
	Nature Trail HealthCare Center	0039586
	Odin HeathCare Center	0039503
	Parkway HealthCare Center	0040857
	Mariner Health of Westchester	0042374

SUPPLEMENATAL SCHEDULE OF ASSETS & LIABILITIES

Line 9

OTHER CURRENT ASSETS:	AMOUNT
Total	0
Difference	
Reconcile with schedule XV, line 9:	0
Difference	0

Line 36

OTHER CURRENT LIABILITIES:	AMOUNT
Misc Dedctns - Employee <> Other Decductions <> Default	-
Misc Dedctns - Employee <> Union Dues <> Default	-
Accruals - Insurance <> Accrue HMO Ins <> Default	-
Accruals - Insurance <> Self Funded Ins Accr <> Default	-
Accruals - Insurance <> Basic Life <> Default	-
Accruals - Insurance <> Lt Dsblty <> Default	-
Accruals - Insurance <> Executive Supp Life <> Default	-
Accruals - Insurance <> Short Term Disability <> Default	-
Accruals - Insurance <> Dependent Life <> Default-Dept	-
Accruals - Insurance <> Accidental Death Dismemberment <> Defa	-
Accruals - Insurance <> NES Insurance <> Default-Dept	-
Misc Dedctns - Employee <> Miscellaneous <> Default	-
Deferred Income <> Deferred Revenue-Blood Glucose <> Default	-
L/T Debt - Current Portion <> Current Portion <> Default	-
Total	-
Difference	
Reconcile with schedule XV, line 36:	0
Difference	-

Line 23

OTHER NON-CURRENT ASSETS:	
Asset Clearing <> Default-Prod <> Default-Dept	-
Asset Clearing <> Default <> Realty	-
Asset Clearing <> Capital Expenditures <> Realty	-
Asset Clearing <> Fresh Start Valuation <> Realty	-
Asset Clearing <> PS AM Capital Expenditures <>FS Realty	-
Asset Clearing <> FAS 121 Impairment Valuation <> Realty	-
Other Assets <> Rfndable Deposits-Int Bearing <> Default	277
Excess Reorganized Value <>Excess Reorg Value <> Default	-
Other Assets <> Rfndable Deposits-Non Int Brg <> Default	-
Total	277
Rounding to bal page	
Difference	
Reconcile with schedule XV, line 23:	277
Difference	-

Line 43

OTHER NON-CURRENT LIABILITIES::	
N/P - Mortgage <> Mortgages <> Default	-
Mortgage Cost <> Current Position <> Default	-
Long Term Debt - Other <> Other <> Default	-
Intercompany - Revolver <> Default <> Default	-
I/C Term Loan 1998 <> Default-Prod <> Default-Dept	-
I/C Term Loan 1999 <> Default-Prod <> Default-Dept	-
I/C - Interunit Asset Transfer <> Default-Prod <> Default-Dept	-
Compromised Liabilities <> Default	-
Other Non-Current Lby <> Rent Accrual <> Default	-
Other Non-Current Lby <> Other <> Default-Dept	-
Other Non-Current Lby <> Overmarket Lease <> Default-Dept	-
Total	-
Difference	
Reconcile with schedule XV, line 43:	0
Difference	0

SUPPLEMENATAL SCHEDULE OF ASSETS & LIABILITIES

DESCRIPTION	AMOUNT
Personal Purchase Receipts <> Default <> Vending	(168)

	Total	-168	Difference
Reconcile with schedule XVII, line 28:		(168)	0

DESCRIPTIONS	
General Revenue <> (General) <> Other	0.00
General Revenue <> (General) <> Other Misc Rev	0.00
Personal Purchase Receipts <> Default <> Patient Personal Purchase	-
Personal Purchase Receipts <> Default <> Miscellaneous Receipts	(1,751)
Personal Purchase Expense <> Default <> Patient Personal Purchase	91
Miscellaneous Receipts <> Default-Prod <> Other Misc Rev	-
Activity Programs Receipts <> Default <> Other Misc Rev	-

			Rounding
	Total	(1,660)	Difference
Reconcile with schedule XVII, line 28a:		(1,660)	-